STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056101	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Pointe Post-Acute	6041 Fair Oaks Blvd Carmichael, CA 95608

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43247 Based on observation, interview, and record review, the facility failed to protect one of three sampled residents (Resident 1) from abuse when Resident 2 hit Resident 1 on the left hand. This failure resulted in a bruise on Resident 1's left hand and had the potential for Resident 1 to feel unsafe in the facility. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in June 2024 with multiple diagnoses including stage 4 pressure ulcer (injury to the skin with full thickness tissue loss with exposed bone, tendon or muscle due to prolonged pressure) of the sacral (base of the spine) region, dementia (loss of memory and thinking skills) and diabetes (too much sugar in the blood). A review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 12/5/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 14 out of 15 that indicated Resident 1 was cognitively intact. A review of Resident 1's SBAR [Situation, Background, Assessment, Recommendation] & Initial COC [Change of Condition]/Alert Charting & Skilled Documentation, dated 2/2/25, indicated .Bruise on left hand . Resident Reports Pain? .Yes .Non-verbal indicators of pain evident? .Yes .about 1045 [10:45 a.m.] Resident reported to this nurse that she was abused by another resident [Resident 2] . who entered in her room .Upon redirecting her out of the room, it was reported that [Resident 2] threw a punch and she sustained bruise on her left hand .Pain medication . offered for the complain [sic] of pain . A review of Resident 1's Care Plan, 2/2/25 Alleged Altercation, [Resident 2] to [Resident 1], initiated 2/2/25, indicated .Interventions/Tasks .2/3/25 Accelerated intervention:- Soft mesh placed across doorway of old room to discourage entry . Apply ice pack as per order Monitor pain Q [every]shift .Physical assessment of the resident's involved . Provide acetaminophen [pain medication] as per order as indicated .Report to provider if pain management not effective . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility in September 2023 with multiple diagnoses including metabolic encephalopathy (the brain does not function properly due to imbalance in the body's metabolism), Horner's syndrome (disrupted nerve pathway on one side from the brain to the face and eye), and dementia. A review of Resident 2's MDS, Cognitive Patterns, dated 1/21/25, indicated Resident 2 had BIMS score of 4 out of 15 that indicated Resident 2 was severely cognitively impaired. A review of Resident 2's SBAR & Initial COC/Alert Charting and Skilled Documentation, dated 2/2/25, indicated .Alleged aggressive physical behavior towards another patient .I am informed by AM RN [Registered Nurse] Supervisor of the following: [Resident 2] with known dementia diagnosis presented with alleged aggressive physical behavior towards [Resident 1] causing a bruise to left hand. Per [Resident 1], [Resident 2] self propelled in her wheelchair into [Resident 1's] room, [Resident 1] became upset and attempted to push [Resident 2], who was in w/c [wheelchair] out of the room. [Resident 2] then punched [Resident 1] in the left hand causing a bruise A review of Resident 2's IDT [Interdisciplinary Team]-Change of Condition/Incident, dated 2/3/25, indicated . Per record review and interviews of staff, Residents, Alleged Abuser (AA) noted with BIMS 4, confused entered another Resident's room [Resident 1] .at approximately 1045 [10:45 a.m.] on 2/2/25, where she (the AA) had resided from 9/25/23 until 1/6/25. Of note, room change was initiated on 1/6/25 due to incompatibility of Roommates .the AA entered [Resident 1's room] (which was her previous room). [Resident 1] reportedly attempted to shoo the alleged abuser out of the room via her wheelchair upon which time the alleged abuser who was in her wheelchair reportedly struck [Resident 1]'s left hand . A review of Resident 2's Care Plan [Resident 2 has the potential to demonstrate physical behaviors .r/t [related to] BPSD [Behavioral and Psychological Symptoms of Dementia], AEB [as evidenced by] resisting ADL [Activities of Daily Living] care, placing others and patient at risk for injury . initiated 1/22/24, indicated . Interventions/Tasks . Modify environment .Monitor and document observed behavior and attempted interventions in behavior log QS [every shift] .When the resident becomes agitated, intervene before agitation escalates, guide away from source of distress . A review of Resident 2's Care Plan [Resident 2] has changed rooms from [Resident 1's room] to [Resident 2's new room] on (1/6/2025) aeb inappropriate behavior and not compatible with current roommate . initiated 1/6/25. A review of Resident 2's Care Plan Alleged Altercation: [Resident 2] to [Resident 1] . initiated 2/2/25, indicated .Goal [Resident 2] will have no further aggressive behavior incidents . During an interview on 2/7/25 at 9:55 a.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 2 was on hospice but had improved, gained strength, is now getting around the facility in her wheelchair and went into Resident 1's room on 2/2/25. The ADON stated Resident 1 asked her to leave and Resident 2 struck Resident 1 on her left arm. The ADON stated there was a bruise, but unable to tell if the bruise was old or new. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 2/7/25 at 10:19 a.m. with the Administrator (ADM), the ADM stated Resident 1 and Resident 2 used to be in the same room and, maybe, out of habit Resident 2 went into the room. The ADM stated Resident 1 was pushing Resident 2's wheelchair out of the room when Resident 2 struck Resident 1. The ADM stated it bruised right away but appeared to be in the healing stage. When asked if there was documentation of Resident 1 having a bruise on her left hand prior to the incident, the ADM stated he was not aware of any bruise but would have to check the clinical record. The ADM stated Resident 1 reported she felt like it was abuse by the other resident. During an interview on 2/7/25 at 12:12 p.m. with Licensed Nurse (LN) 2, LN 2 stated Resident 2 came down the hallway and entered her old room. Resident asked her to leave, and Resident 2 struck Resident 1. During a concurrent observation and interview on 2/7/25 at 12:26 p.m. with Resident 1, Resident 1 stated she requested a couple of weeks ago Resident 2 be moved to different room because Resident 2 would get into her things and would bother her and her visitors. Resident 1 stated Resident 2, Had been following me all over, giving me dirty with looks .Came into my room with her arms crossed, staring at me. Resident 1 stated she pushed Resident 1's wheelchair back into the hall and Resident 1 struck her on the left hand. Observed Resident 1's back of left hand with area of dark purple discoloration above thumb and dark purple discoloration above second, third, and fourth fingers from knuckles to the middle of the back of the hand. Resident 2 stated, Called 'help' because [Resident 2] was ready to hit me again .She is just aggressive. During an interview on 2/7/25 12:45 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 is sometimes combative, resists care and has struck staff. CNA 1 stated Resident 2 will strike out if you tell her what to do and if she is in a mood will hit staff. During a record review on 2/7/25 at 12:52 p.m. of Resident 1's skin assessments and nursing assessment prior to incident on 2/2/25, did not identify any documentation of bruise on left hand. During a concurrent interview and record review on 2/7/25 at 1:34 p.m. with the ADON, reviewed Resident 2's Care Plans and staff interviews that indicated Resident had aggressive behaviors and could be combative. The ADON stated he was not aware of Resident 2's aggressive behaviors. During an interview on 2/7/25 at 1:41 p.m. with the Social Services Director (SSD), the SSD stated Resident 2 has been on psychotropic medications for behaviors including striking out at staff during ADL (Activities of Daily Living) care. The SSD stated Resident 1 reported to her that Resident 2 did not like her. A review of the facility's Policy and Procedure (P&P), titled Abuse Prevention Program, revised 12/18, indicated Our residents have the right to be free from abuse .This includes but is not limited to freedom from . physical abuse .As part of the resident abuse prevention, the administration will .Protect out residents from abuse by anyone including .other residents . Identify and assess all possible incidents of abuse .Protect residents during abuse investigations . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility's P&P titled Abuse and Neglect-Clinical Protocol, revised 3/18, indicated .Abuse is defined .as the willful infliction of injury .with resulting physical harm, pain or mental anguish. It includes . physical abuse .Willful as defined .and as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or ham .The physician and staff will address appropriately causes of problematic resident behavior . A review of the facility's Policy and Procedure (P&P) titled Resident-to-Resident Altercations, revised 12/16, indicated .All altercations, including those that may represent resident-to-resident abuse, shall be investigated .Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents .